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ChoiceCare Health Services

A Case Study of an IPA in Ft. Collins, Colorado

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Ft. Collins, Colorado

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Public Health Service
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I. INTRODUCTION

At the end of December, 1979, the 35,000 member ChoiceCare Health Services, Ft. Collins, Colorado, ceased operations as a federally qualified individual practice association (IPA) health maintenance organization (HMO). ChoiceCare closed because the physician component, the IPA, refused to negotiate a new contract.

The reaction from observers within the HMO industry was quick and, in many instances, inappropriate. Most said the plan closed because the "doctors just quit". But that is only part of the ChoiceCare story. While it is true that the physicians did not renew the contract, significant underlying factors contributed to the plan's demise. This case study will address some of the factors that led to ChoiceCare's closing.

Research to gather information for this report was limited to review of federal government records and to interviews with government officials, former ChoiceCare employees, and others associated with ChoiceCare.

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II. HISTORY AND BACKGROUND

ChoiceCare was developed from a Foundation for Medical Care that had been formed in Larimer County in 1971 by a group of physicians who were concerned about what they perceived as inadequate health insurance coverage for their patients. They were interested in providing broader benefits for outpatient care. In late 1971, the Medical Care Foundation applied for and received federal grant funds to study the feasibility of an HMO in Larimer County. The development of an IPA/HMO started under the direction of Richard Siever with the assistance of InterStudy, a Minneapolis based health policy research firm. After Richard Siever resigned in September, 1972, George Cowan became Executive Director.

During the period of development (1971 through April 1974), activities focused on organization and administrative structure, with a great percentage of the director's time being spent on getting the HMO enabling legislation passed in the State of Colorado.

ChoiceCare Health Services, Inc., was incorporated as a nonprofit organization on October 29, 1973. The by-laws were adopted in November, 1973. They called for 15 directors, 12 of whom were participating physicians in the health plan. The Larimer Physicians Service Corporation (the IPA) also applied for legal status as a professional corporation, since it would provide medical services for the enrollees of ChoiceCare. The IPA had five board members who eventually became members of the ChoiceCare board.

A. Initial Operation

ChoiceCare became operational on April 1, 1974. Almost immediately problems developed. The marketing effort did not prove to be successful. The main problems were gaining access to employees to explain the ChoiceCare program and the reluctance of many employers to offer workers the HMO option until the Section 1310 (Dual Choice) federal regulations were published. HEW Regional Office staff reported that the optimistic assumptions of the marketing strategy were unfounded. Also, the sales representatives were not well trained in the HMO concept, nor did they have the necessary marketing skills. Between April, 1974, and April, 1975, ChoiceCare enrolled about 3,000 persons, substantially fewer than the initial projections.

Another major problem was the disagreement by the physicians about the plan's pricing of their services. An actuarial consultant determined that the preliminary calculations had been based on incorrect methodology. A report by the HEW Regional Office in July of 1974 stated that physician participation appeared strong, but "actually, recurrent fears about potential federal involvement in the private practice of medicine may relate to continuing difficulties in getting the HMO off the ground."

From mid-1974 through 1975, ChoiceCare was receiving grant funds (see Appendix) to enable it to work towards meeting the requirements of federal qualification. During this time many serious management problems began to surface.

One of the problems was the strong disagreement between the staff and certain physician board members over the way the plan was managed. The president of the board resigned and three physician vacancies on the board went unfilled. Then,

in July, 1975, three physicians, one hospital administrator, and one nursing care facility administrator resigned from the board. Although the IPA voted (54 to 1) to replace the Executive Director, ChoiceCare's board of directors retained him. The physicians also questioned whether they should renew their contract in view of the plan's management problems. Excessive staff turnover was another problem. Ten staff members had resigned, including the Medical Director and the Controller.

Despite the apparent unrest and confusion that existed between the plan and the physicians, the plan agreed to a qualification site visit in February 1976. The reports of the site visit team indicated that ChoiceCare would have to make major changes in order to become a qualified HMO. The Plan was denied qualification in March 1976 for a number of reasons, the main ones being:

1. The physicians were not consistent in their support for the plan. One week before the site visit, the IPA voted 45 to 10 not to renew their contract with the plan when it expired in December, 1976. The physicians indicated that they were dissatisfied with the method of payment (they preferred fee-for-service), the risk pool arrangement, and the administration of the plan.
2. Management at the top of the organization was not effective. The Executive Director, George Cowan, left the plan at the end of March, 1976.
3. The marketing plan was not acceptable. Membership was just over 3,100 and appeared to be at a standstill. ChoiceCare was experiencing high disenrollment and low penetration rates.
4. Actual deficits were exceeding projected deficits, because utilization

controls were ineffective and partially because the value of the physicians' claims exceeded the capitation rate. Also, use of unaffiliated specialists was extensive even though the plan had a full complement of physicians.

In an effort to save the government's investment in ChoiceCare, the HEW Regional Office staff looked for ways to strengthen the organization. They hoped that new management could convince the physicians to continue. E. W. "Buzz" Sandberg, Ph.D., then a consultant to the HMO program, was part of a team sent out to evaluate the situation. The Regional Office staff asked Dr. Sandberg to take a look at ChoiceCare and talk to the physicians. The ChoiceCare board hired Dr. Sandberg as Executive Director in April, 1976.

Shortly after Dr. Sandberg came on board he began to turn the plan around. All reports were positive. The physician relationship with the plan was strengthened and the majority of physicians voted to remain with the plan (May, 1976).

The favorable IPA vote and the new director's competence apparently resolved two of ChoiceCare's major problems. There were now 93 participating physicians out of 120 in the county. Six months after the initial qualification denial, ChoiceCare was approved as a federally qualified HMO (August 12, 1976), and received a $728,000 federal loan.

B. Post-Qualification

Dr. Sandberg began to bring on key staff members, hiring a financial and a marketing manager. All reports submitted to the HMO office showed positive signs.

Membership grew from 6,543 in January, 1977 to 17,707 in January, 1978. A surplus of $182,286 was reported in 1978. There were no indications that the plan was in trouble. Rather, it was considered to be a model IPA.

In early 1977, ChoiceCare applied for grant funds to expand the plan into Weld County. Funds were received in July, 1977. A separate IPA was established in Weld County, and the program began there in January, 1978, with Jim Smid as director. He had previously been involved in other aspects of ChoiceCare's management. About 98 percent of the Weld County medical community participated in the IPA. Claims and utilization review were done in Weld County, but the payments were made by ChoiceCare out of Ft. Collins.

In March of 1978, the HEW Regional Office, based on a review of the ChoiceCare operation, requested that ChoiceCare be investigated because of the possibility of inappropriate activities. Specifically, the Regional Office was concerned about the lease/purchase agreement on the building which housed ChoiceCare, the contract for computer services, and internal management practices.

In May of 1978, a management letter prepared by ChoiceCare's auditors, Erickson, Hunt and Spillman, enumerated 14 areas in the internal accounting and control system which they believed had serious weaknesses.

Two staff members of the OHMO Central Office conducted a fact-finding site visit in July, 1978, to investigate these issues. No evidence of illegal activity was found. Their report cited instances of poor judgment and poor business practices by ChoiceCare staff. Some of the practices cited were:

1. There was confusion about the contract for computer software services and "sloppy technical procedural practices" concerning payment to the computer firm.

2. ChoiceCare maintained little internal control. The system of recording income and expenditures and maintaining the accounting records was entirely inadequate.

3. The plan had no system of inventory accounts and no detailed list of fixed assets.

4. A marketing employee was responsible for maintenance of the detailed accounts receivable, he performed this function with little supervision and training.

5. Cash funds were not reconciled to the cash records during most of the year, and the checks were written without supporting documentation.

Recommendations for corrective action were made, and the ChoiceCare board and management agreed to institute changes.

In May, 1979, a financial specialist from the Regional Office visited ChoiceCare to determine whether any problems might prevent the plan from making loan payments and to review the administration of the escrow agreement. He discovered that ChoiceCare was submitting monthly data summaries reflecting far more favorable operating results that those shown in the independent auditor's report. The plan's controller stated that he provided no information for the preparation of the monthly reports.

Dr. Sandberg resigned as Executive Director on June 1, 1979. The auditor's report for 1978 (dated June, 1979) again alerted OHMO to trouble concerning ChoiceCare's accounting and management practices. A series of site visits took place in the late summer of 1979. After review of the site visit reports, OHMO sent a letter of non-compliance to the plan. In August, 1979, Ed Petras assumed the position of Executive Director. Mr. Petras, who had previously directed an IPA/HMO in Marion, Ohio, believed that he could rehabilitate ChoiceCare within 18 months. In December, however, the physicians

voted not to renew their contract and the board of directors voted for the plan's closing.

III. ADMINISTRATION

Although ChoiceCare employed a large staff of "key managers," these managers did not appear to be functioning as such. The principles of participative management and delegation of major responsibilities to key managers were not employed. The board of directors either could not or would not act responsibly toward directing the plan based on the information the board received from management. It appears that the board did not have sufficient knowledge of the plan's operation.

IV. MARKETING

ChoiceCare's initial service area, Larimer County, was expanded to include Weld County in January, 1978. Together, the two counties have a population of 325,000. Ft. Collins, the largest city in Larimer County, is a university town, and there are several major employers in the area as well, including Hewlett-Packard, Kodak, NCR, Teledyne, and Bell Telephone. Before ChoiceCare was developed, most residents had health care coverage through commercial insurance carriers. Blue Cross had only a small share of the market.

When ChoiceCare was qualified in 1976, there were 3,000 enrollees in the plan. At the time ChoiceCare went out of business, it had approximately 35,000 members. Of these, 72 percent belonged through commercial accounts and 28 percent were enrolled through government programs. Membership growth after qualification had been dramatic and was taken by many to be the prime indicator of the plan's success.

The following chart illustrates membership growth since qualification.

	Actual	Projected
January 1977	6,543	4,850
January 1978	17,707	17,650
January 1979	26,582	27,500
December 1979	35,000	35,250

The plan's financial projections predicted that ChoiceCare would break even at 12,000 enrollees and that the federal loan would be repaid by the time the plan had enrolled 20,000 members. In September, 1979, 202 employer groups were offering the ChoiceCare program. This resulted in a commercial enrollment of 25,244. Medicare enrollment was close to 3,000 and Medicaid was at 4,611. The original goal of 12,000 had been met in 1978, and yet at the end of September, 1979, ChoiceCare still had not reached breakeven. In fact, the cumulative deficit reported through June, 1979, exceeded $1 million.

ChoiceCare's marketing staff consisted of a marketing director (also serving as a marketing representative for Larimer County), two additional commercial marketing representatives, two Medicare and Medicaid representatives in each of the counties, a member services representative, an enrollment clerk, and a secretary. The marketing director apparently functioned as a "super salesman" rather than as a member of the management team, although there is disagreement on this point. Planning and marketing strategies seemed to be nonexistent. There were no specific formulas for work production, and individual representatives were not required to submit periodic planning

reports. All review of activities was retrospective. Specific marketing reports were not prepared for the board of directors or ChoiceCare's senior management.

Rather than a well-formulated marketing strategy, a "shotgun" approach appeared to be used in dealing with prospects. Heavy emphasis was placed on securing Medicare and Medicaid business, even though the greater potential existed in the commercial market (although 85 percent of the potential Medicaid market in Larimer County had been enrolled by August, 1979, a Medicaid marketing representative continued to be employed). ChoiceCare acted as the fiscal intermediary for all Medicaid recipients. Physicians had a real incentive to encourage Medicaid recipients to enroll in the plan, since the reimbursement from Medicaid for non-ChoiceCare patients was only about 60 percent of usual, customary, and reasonable (UCR) fees.

In March, 1979, it became apparent that ChoiceCare's difficulties might be insurmountable. Hospitals and physicians complained that they were not being paid on time. Utilization was going up. Apparently, utilization controls were not being used or enforced. The rationale for the increased use was a "sick winter quarter". The financial report for the first quarter showed a deficit of $547,998. Marketing efforts increased in an attempt to make up the deficit, but this only exacerbated the situation, since the premiums were inadequate to cover the cost of care provided. Without records, it is difficult to determine how much the plan was losing. It is alleged the loss was at least $3 per member per month.

V. PROVIDER COMPONENT

A. Hospitals

There were three hospitals in Larimer County and two in Weld. In September of 1979, none of the three Larimer County hospitals had contracts with ChoiceCare. One of these hospitals was hardly ever used; the other two were used by ChoiceCare, each serving its own geographic population. One of the hospitals in Weld County had a contract with the plan. Hospital utilization figures for the ChoiceCare commercial accounts in 1978 were 441 days per thousand for Larimer County and 729 days per thousand for Weld County.

B. Physician Services

Over 90 percent of the physicians in the two-county area belonged to the IPA. There were separate IPAs for each county. As is frequently the case with IPA/HMOs, neither IPA had a staff. All administrative and operational support was provided by ChoiceCare from its Ft. Collins office.

The agreements between the IPAs and ChoiceCare stipulated that ChoiceCare was to pay the agreed-upon capitation rate to each IPA per member per month. The rate was to guarantee the physicians 90 percent of UCR for services rendered. The problem was that the amount of service being performed was greater than the funds provided by the capitation. The physicians, however, continued to receive 90 percent of UCR. One of the doctors estimated that, in 1978, the physicians were paid about $300,000 more than the value of their fund, based on the capitation rate. The doctors therefore were not truly "at risk" and did not really understand the nature of the financial relationship in which

they had been engaged. Their contracts with the IPA made no mention of what would happen if there were to be a deficit in the fund.

Each IPA was governed by a five-member board of directors which met monthly. Each of the IPA board members sat on the board of ChoiceCare. The IPA bylaws stated that the secretary-treasurer "shall have charge and custody of and be responsible for all funds and securities of the corporation". The IPAs relied completely on the HMO management for all information relating to the determination of their compensation and assessment of their financial condition.

There were three medical directors for the two IPAs: Dr. Kenneth Olds was the director for Weld County, Dr. Richard Roark was the director for commercial members in Larimer County, and Dr. Donald Wells the director for the Medicaid/Medicare members. Their major responsibility was to review claims for questions concerning appropriateness of service or charges.

Questions concerning the practice of medicine were generally referred by the medical director to a peer and utilization review committee. Each IPA had a committee, providing a level of review above that of the medical directors. The peer and utilization review committees reviewed claims and denied payments to physicians when services were not considered appropriate. Physicians in question had a chance to present their views to the committee and could appeal to the IPA board and eventually to the ChoiceCare board if necessary.

Other responsibilities of the medical directors included approving referrals to non-plan physicians and providers, initiating quality assurance through

development of protocols, and giving approval to non-group applications for ChoiceCare enrollment. Although referrals to non-plan providers had to be approved in writing by a medical director, there was no system for control of in-plan referrals except through retropective utilization review.

Two nurses in Larimer County and one part-time nurse in Weld County visited the hospitals each day to assign length of stay for ChoiceCare members. Questionable hospital stays were reviewed by the physician advisor of each hospital, who was paid on an hourly basis by ChoiceCare.

VI. FINANCE AND MANAGEMENT

Broad discrepancies existed between the financial information reported by the plan and the independent auditors. ChoiceCare reported the following suplus/(deficit) figures: 1976 -- ($53,567); 1977 -- ($320,234); 1978 -- $182,286; first quarter 1979 -- ($547,999); and second quarter 1979 -- $214,781.

The auditor's report indicated a deficit of $243,467 prior to 1977, a deficit in 1977 of $260,998, and a deficit in 1978 of $458,742. The cumulative deficit through 1978 was $963,204, and at the end of the second quarter of 1979, an additional $333,218 had brought the total deficit to $1,296,424.

In August, 1977, ChoiceCare's audit firm advised the board that a full-time accountant was needed. Until then, the accounting had been done only by a bookkeeper. In June, 1978, Lawrence Vance was hired as Financial Director.

In May, 1978, the auditors for ChoiceCare (Erickson, Hunt and Spillman of Ft. Collins) studied and evaluated the system of internal accounting controls

for the year ending December 31, 1977. They notified ChoiceCare of certain material weaknesses that they had identified. These items were considered to be significant enough that a formal report was issued for the ChoiceCare board. ChoiceCare's management sent a formal memorandum to the board of directors stating that some of the deficiencies had already been corrected and agreeing to correct the others.

ChoiceCare's board forwarded this response to the federal Office of HMOs. ChoiceCare's response addressed all the issues but it nevertheless proved to be inadequate. Management did not satisfactorily resolve all the problems. Examples of some of the items identified by the audit firm and ChoiceCare's response are given below.

1. The auditors determined that it was imperative that computerization of accounts receivable, billing, and general accounting functions be achieved as quickly as possible. In June, 1977, ChoiceCare had signed a contract with a firm for the development and installation of a computer program. Funds had been advanced to the firm but the program was behind schedule. A recommendation was made to establish a realistic timetable for computerization after a proper in-depth evaluation of ChoiceCare's needs.

Response: New personnel have been hired to staff the accounting department, including a certified public accountant. Significant progress has been made toward computerizing the accounting function. Portions of the system are not operational, and the entire system should be functional by October 15, 1978.

The entire computer system was not functional by October, 1978. In August of 1979, there were still major portions of the financial component that were incomplete.

2. An area of concern was cash disbursements. The auditors noted several problems such as checks not being issued in strict numerical sequence and instances of improper monthly cutoffs of disbursements. They noted that some checks were written without supporting documentation, or released without proper signatures; voided checks were handled inadequately. They also noted disbursements for personal expenses of a ChoiceCare employee. Benefit vouchers were not adequately referenced as to the source of disbursement. In many instances benefit vouchers had been lost or misfiled.

Response: Checks are under the supervision of the Director of Finance and the accounts payable clerk. All checks are strictly controlled. New procedures have been instituted to verify issuance in proper order as well as proper month-end cutoff. These changes were developed and accomplished prior to receipt of the management letter.

Response: All disbursements require proper documentation prior to approval. This change was instituted on or about June 1st, 1978, prior to receipt of the management letter.

Response: The personal disbursement was an oversight on the bookkeeper's part in that the employee in question was to have his next paycheck reduced. ChoiceCare has since been reimbursed. The check control policy

referred to in Item 3 will preclude this from reoccurring. Management has reaffirmed the policy of strict separation of personal and corporate transactions.

Response: Prior to receipt of the management letter, the accounting department began attaching a copy of the check to each voucher, as of June 1.

Response: A new filing system has been initiated, utilizing envelopes to contain all claim forms within each voucher. This change was designed and implemented by August 2, 1978.

3. The next area of concern to the auditors was premium income and accounts receivable. There was no attempt to reconcile any of the actual amounts received with the amounts due on individual accounts or to reconcile the total receivables to the accounting records. There were also inadequate records for larger member groups, resulting in large unreconciled discrepancies. Individual subscriber accounts were not monitored. Member eligibility was not current. Some duplicate billings for medical benefits were made. Medicare co-payments were computed solely on the physician's billings. Salaries and payroll bonuses were not included in the payroll record as salaries, and appropriate taxes were not being withheld. In addition, no written authorizations were retained for salary increases.

Response: Currently all large groups are reconciled monthly, with the exception of the Federal Employees Health Benefit Plan. Procedures

are being formulated for a comprehensive positive billing system. Implementation of this system must await completion of computer programming now in progress and manual reconciliation of existing discrepancies. We expect to implement the positive billing system by October 1, 1978.

Response: Member eligibility is now current, and is updated daily.

Response: It has proven impractical to check for duplicate billings manually. The medical claims processor (as well as other computer processors) will eliminate this problem. All processing systems have been automated, and, therefore, we expect to reduce the potential of duplicate payments.

Response: Substantially all Medicare billings now come directly from physicians. In those cases where the physician first bills an intermediary, either a copy of the intermediary's remittance or an explanation is requested from the physician. Further, ChoiceCare will in the next 60 to 90 days perform both Medicaid and Medicare audits on all three Larimer County Hospitals to ascertain that payments to those institutions were correct.

Response: Bonuses are now handled properly in accordance with IRS regulation. This was accomplished prior to receipt of the management letter.

Response: A new payroll action request form has been developed to document all payroll actions. This system was fully implemented by July 1, 1978.

4. State and local sales taxes were not paid on all invoices. Local use tax returns were not filed.

Response: All taxes included on invoices are not paid. While local use taxes are not considered significant in dollar amount, an audit will be made to determine ChoiceCare's liability. This information will be supplied to the Finance Committee of the Board for their action by November 15, 1978.

5. Fixed asset accounting was nonexistent. There was no system inventory account nor was there a detailed list of ChoiceCare's assets.

Response: Provision for computerization of fixed asset accounting is currently being made. The system should be working within 30 to 60 days, with a goal of implementation prior to November 1, 1978.

6. Regarding Medicaid, the auditors found a general lack of working knowledge in ChoiceCare's accounting department. The savings provision of the Medicaid contract required a reconciliation which had not been accomplished. At no point during the year had the accounting department reconciled the Medicaid account receivables, nor did the accounting records agree with the correct income for the fiscal agent portion of Medicaid.

Response: The accounting department had inadequate knowledge of Medicaid accounting. The "savings" provision of the Medicaid contract requires a reconciliation which had not yet been accomplished.

7. Overall, serious deficiencies in the accounting functions were noted. Even though the bookkeeper performed commensurate with her abilities, her capability fell far short of the needs of ChoiceCare. There were few internal control mechanisms, and the system of recording income and expenditures and maintaining the accounting entries was inadequate. The computerized system was incomplete and a recommendation was made that high priority be placed on the adaptation of the computer to the accounting function.

As of August, 1979, the financial component of the computer system was still incomplete.

The audit firm performed another independent audit for the year ending December, 1978. A management letter, dated June, 1979, again raised questions about ChoiceCare's business practices. A number of issues from the previous year's audit had not yet been corrected.

VII. COMPUTER SYSTEM

ChoiceCare's computer system evoked controversy and disagreement. The main problems were: 1) The contract between ChoiceCare and the system vendor was loosely worded, leading to poor execution; 2) Due to a variety of difficulties and underestimation of the tasks involved, the vendor consistently missed scheduled deliverables and deadlines; and 3) ChoiceCare agreed to serve as a model for computer systems to be placed in other IPAs, and was to have received a royalty of 20 percent on the first 10 placements of the system and 10 percent on all placements after that.

On June 15, 1977, ChoiceCare signed a contract for the computer program costing $15,000. The original contract specified that programming services were to be delivered in three phases and all three phases would be completed by December 31, 1977. However, on the date when all computer work was to be finished, Phase I and II had not been completed and Phase III was only partially operational. Although the vendor was well behind schedule and out of compliance with the terms of the contract, they had been advanced some $9,000 in fees. By mid-March 1978, the firm already had been paid the full $15,000 fee and the system was not yet fully operational. Throughout the data processing at ChoiceCare, there were indications of significant difficulties. It was alleged that the computer firm had received $39,211 in payments not supported by documentation. Because the computer originally selected for ChoiceCare did not have the functional capability necessary for the type of program being written and the size of ChoiceCare's membership, a computer with larger capacity was leased.

At the request of OHMO's Denver Regional Office, an outside consultant firm conducted an in-depth analysis of the financial and technical capabilities of ChoiceCare computer system in mid-August, 1979. The purpose of the assessment visit was to determine the current operational status of the ChoiceCare system, its major deficiencies, and the reasons why it failed to predict ChoiceCare's financial shortfall.

The consultants determined that ChoiceCare's accelerated growth from early 1977 through mid-1979 had placed severe strains on the ability of hardware and software resources to support the associated data processing workloads. To some extent, this problem had been rectified by continuous upgrading

of the hardware to higher minicomputer models. However, both ChoiceCare management and the computer vendor personnel seriously underestimated the level of effort required to develop operational software in accordance with the original design expectations. The result of this miscalculation was that many software applications were delivered late, and several financial applications originally promised for 1977 were not completed. Many other enrollment and claims software applications had residual bugs after their installation that required continuous repair or modification.

At the time of the consulting firm's assessment (August, 1979), the ChoiceCare software appeared to be approximately 80 to 90 percent complete, with most components of the enrollment and claims processing subsystems functioning satisfactorily. The major software applications still outstanding were in the financial areas of premium accounts receivable, provider accounts payable, accrual/lag reporting, financial planning, and general ledger.

The consultant's overall conclusion was that the computer system employed at ChoiceCare was not functioning in an optimal manner, but could be salvaged and enhanced by addressing the problems and recommendations stated in the assessment report. While the system did contain flaws in the eligibility and claims areas, the majority of problems associated with the system were due to the incomplete and inadequate state of the financial applications.

Specific conclusions of the assessment are listed below:

1. A formal system planning and management process does not exist.
2. A loose working relationship with the system vendor has further contributed to overall software development problems.
3. The software development effort has been plagued by late deliverables and post-installation bugs.

4. Security and control mechanisms used to store vital enrollment application records are unacceptable.

5. Procedures employed to control and prepare data for input to the computer are inadequate and inefficient.

6. Current financial and administrative support systems used by ChoiceCare have internal control problems.

7. Current financial processes employed have feature deficiencies.

8. Current lag reporting and accrual techniques are inadequate.

9. MIS costs appear to be quite moderate based on the limited supporting information available.

10. User documentation is inadequate to support the daily MIS activities of Plan personnel.

11. Regular technical and user training programs are not employed to educate ChoiceCare personnel about key MIS activities.

The consultant report went on to discuss each conclusion in detail and recommend immediate corrective action and specify plans for long-range needs. Before any of these recommendations could be fully carried out, ChoiceCare ceased operations.

VIII. FINAL DAYS

At the beginning of 1979, ChoiceCare's board and employees thought things were going well. They believed there was a $120,000 surplus and that the risk fund would be distributed to the physicians. At that point, the physicians were being paid 90 percent of their usual, customary, and reasonable fee, and it was believed that 10 percent was being put into a risk pool.

Instead of disclosing a surplus, the audit conducted by Erickson, Hunt, and Spillman found serious financial problems. The audited balance sheet

for calendar year 1978 revealed a cumulative operating deficit of $963,204. The unaudited balance sheet for the quarter ending June 30, 1979, showed an additional deficit for the first six months of 1979 of $333,000. The total operating deficit through June, 1979, based on audited and unaudited figures was $1,296,204.

In April of 1979, Dr. Sandberg had announced his decision to leave ChoiceCare, and he did so on June 1. Ed Petras then joined ChoiceCare as its Executive Director in September, 1979, and hired several new staff members and set about trying to rehabilitate the plan. Mr. Petras was faced with two major tasks: first, developing a contract that would be acceptable to the physicians in Larimer County, and, second, answering a letter of non-compliance from HEW.

When Ed Petras joined ChoiceCare, the physicians informed him that they intended to renegotiate rather than renew the contract as it was written. At that point, the physicians had been guaranteed 90 percent payment regardless of what was currently in the capitation fund. It appears, therefore, that ChoiceCare was operating more as an insurance company (but without sufficient premium income and underwriting) than as an HMO.

Ultimately, after ChoiceCare's board met with HEW and other advisory groups, the board made a proposal to the physicians: they would receive 90 percent of their charges if they maintained the same hospital utilization in 1980 as they had in 1979 (435 days per 1,000 members). The physicians were further told that, if they could improve the hospitalization figures by 5 percent and achieve a 5 percent reduction in hospital days, they would receive 100 percent reimbursement.

The physicians voted 92 to 24 to reject the contract and agreed to make no further efforts to negotiate a new one. Part of the rationale for that action seems to be that there had been no risk for hospitalization before. The physicians felt that the hospital utilization rate in the community was as low as it could possibly be without compromising patient care. Preliminary figures (unverified) indicate that the physicians may have been correct in that there was apparently a surplus of funds in the hospital pool.

On December 18, 1979, the board of directors of ChoiceCare voted to terminate operations. The plan was immediately turned over to the State for conservatorship.

IX. CONCLUSION

It is evident that many factors led to ChoiceCare's closing.

ChoiceCare was established in an area where there was no competition from any other HMO. As a result, it appears that incentives for efficiency and cost controls were missing. The plan was fortunate in that the area historically had had low hospital utilization rates. Still, outpatient services were heavily used and the premium was set too low to cover them.

The medical community had poor knowledge of the HMO concept. The physicians had little or no understanding of both the risk-sharing arrangements and the responsibilities for controlling utilization and costs necessary to operate a viable IPA/HMO. Clearly, this lack of awareness existed from the outset. Yet, the plan management never addressed the issue nor attempted to educate

the physicians about the HMO concept.

Physicians in the Larimer County IPA were dissatisfied with their contract from the beginning. Coupled with the other problems, this dissatisfaction led to their refusal in December, 1979, to continue with the IPA. The final straw was the request to further cut down on hospital usage, which they believed would compromise the quality of care. It is uncertain how much the physicians were receiving in reimbursement and just how the payments were being made, whether from a capitation fund or as billed. In the end, it appears that ChoiceCare was being operated as an insurance company rather than an HMO. But the plan lacked sufficient premium income and underwriting to succeed as an insurance company.

ChoiceCare suffered the consequences of choosing ineffective executive directors and of not holding them accountable for the operation of the plan. The negative consequences of these shortcomings plagued the plan throughout its life. Many of the key managers (finance, marketing, medical director) did not perform their jobs well or were not held accountable. Internal administration was too loose. The plan's records were so incomplete and inaccurate, according to the firm that audited ChoiceCare, that while plan personnel thought ChoiceCare had a $120,000 surplus, in fact, the plan was more than $1 million in debt.

The board of directors did not exercise appropriate oversight. It appears that the board either could not or would not make responsible decisions in monitoring the operation of the plan. Also, ChoiceCare's "shotgun" marketing approach resulted in an impressive number of enrollees but was probably a major factor in the plan's failure to survive.

ChoiceCare's demise provides a valuable lesson regarding the difficulties that can arise unless monitoring systems are efficient and unless enrollment growth is controlled to assure that the organization support systems can handle the growth. ChoiceCare's experience should, at least, offer some helpful guidelines in the development and management of other IPA/HMOs.

APPENDIX

FEDERAL AID TO CHOICECARE HEALTH PLAN

GRANTS

Planning: 1/1/72 - 9/30/72	$ 25,000
Initial Development: 7/1/72 - 1/30/74	163,427
Initial Development: 7/1/73 - 12/31/74	110,173
Initial Development: 10/1/74 - 9/30/75	203,000
Initial Development: 10/1/75 - 8/31/76	55,497
Feasibility - Weld County Expansion: 8/77 - 9/77	22,340
Planning - Weld County Expansion: 12/77 - 4/78	68,521

LOAN

August 12, 1976	$ 728,000

TIMETABLE

Foundation for Medical Care established	1971
ChoiceCare's first director resigns; Cowan becomes executive director	9/72
ChoiceCare incorporated as nonprofit organization	10/29/73
By-laws adopted	11/73
Plan becomes operational	4/1/74
First year enrollment: 3,000	4/74 - 4/75
Serious management problems	1974 - 1975
Board members resign, board vacancies unfilled, board retains Cowan despite IPA vote to replace	7/75
Physicians vote not to renew contract; OHMO conducts qualification site visit	12/76
Qualification denied, executive director Cowan replaced by Sandberg	3/76
Physicians vote to remain in plan	5/76
Federal qualification approved	8/1/76
Weld County IPA becomes operational	1/78
OHMO Regional office requests investigation	3/78
Auditors list areas of weakness	5/78
OHMO conducts site visit, make citation of poor practices	7/78
Regional office financial specialist investigates	5/79
Sandberg resigns	6/79
OHMO conducts site visits to assess compliance	Summer 1979
Petras becomes executive director	8/79
Physicians vote not to renew contract; ChoiceCare ceases operations with 35,000 members	12/79

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